106TH CONGRESS
2D SESSION

S. 3017

To amend the Social Security Act to establish an outpatient prescription drug assistance program for low-income medicare beneficiaries and medicare beneficiaries with high drug costs.

IN THE SENATE OF THE UNITED STATES

SEPTEMBER 7, 2000

Mr. ROTH (for himself, Mr. JEFFORDS, Mr. MURKOWSKI, Mr. CAMPBELL, Mr. STEVENS, and Mr. FRIST) introduced the following bill; which was read twice and referred to the Committee on Finance

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A BILL

To amend the Social Security Act to establish an outpatient prescription drug assistance program for low-income medicare beneficiaries and medicare beneficiaries with high drug costs.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Medicare Temporary Drug Assistance Act''.

SEC. 2. OUTPATIENT PRESCRIPTION DRUG ASSISTANCE PROGRAM.

(a) ESTABLISHMENT.—The Social Security Act (42 U.S.C. 301 et seq.) is amended by adding at the end the following new title:

''TITLE XXII—OUTPATIENT PRESCRIPTION DRUG ASSISTANCE PROGRAM

''SEC. 2201. PURPOSE; OUTPATIENT PRESCRIPTION DRUG ASSISTANCE PLANS.

''(a) PURPOSE.—The purpose of this title is to provide funds to States to enable States, individually or in a group, to establish a program, separate from the medicaid program under title XIX, to provide assistance to low-income medicare beneficiaries (as defined in section 2202(b)) and, at State option, medicare beneficiaries with high drug costs (as defined in section 2202(c)) to obtain coverage for outpatient prescription drugs.

''(b) OUTPATIENT PRESCRIPTION DRUG ASSISTANCE PLAN REQUIRED.—A State may not receive payments under section 2205 unless the State, individually or as part of a group of States, submits in writing to the Secretary an outpatient prescription drug assistance plan under section 2206(a)(1) that—

''(1) describes how the State or group of States intends to use the funds provided under this title to provide outpatient prescription drug assistance to

low-income medicare beneficiaries and, if applicable, medicare beneficiaries with high drug costs consistent with the provisions of this title;

''(2) includes a description of the budget for the plan (updated periodically as necessary) and details on the planned use of funds, the sources of the non-Federal share of plan expenditures, and any requirements for cost-sharing by beneficiaries;

''(3) describes the procedures to be used to ensure that the outpatient prescription drug assistance provided to low-income medicare beneficiaries and, if applicable, medicare beneficiaries with high drug costs under the plan does not supplant coverage for outpatient prescription drugs available to such beneficiaries under group health plans; and

''(4) has been approved by the Secretary under section 2206(a)(2).

''(c) ENTITLEMENT.—Subject to subsection (d)(2), this title constitutes budget authority in advance of appropriations Acts and represents the obligation of the Federal Government to provide for the payment to States, groups of States, and contractors described in section 2209(a)(2)(A), of amounts provided under section 2204.

''(d) PERIOD OF APPLICABILITY.—

''(1) IN GENERAL.—No State, group of States, or contractor described in section 2209(a)(2)(A), may receive payments under section 2205 for outpatient prescription drug assistance provided for periods beginning before October 1, 2000, or after September 30, 2004.

''(2) MEDICARE REFORM.—If medicare reform legislation that includes coverage for outpatient prescription drugs is enacted during the period that begins on October 1, 2000, and ends on September 30, 2004, this title shall be repealed upon the effective date of such legislation, and no State, group of States, or contractor described in section 2209(a)(2)(A) shall be entitled to receive payments for any outpatient prescription drug assistance provided on or after such date.

''SEC. 2202. BENEFICIARY ELIGIBILITY.

''(a) ELIGIBILITY.—

''(1) IN GENERAL.—In order for a State (individually or as part of a group of States) to receive payments under section 2205 with respect to an outpatient prescription drug assistance program, the program must provide, subject to the availability of funds, outpatient prescription drug assistance to each individual who—

''(A) resides in the State;

''(B) applies for such assistance; and

''(C) establishes that the individual is—

''(i) a low-income medicare beneficiary (as defined in subsection (b)); or

''(ii) at the option of the State, a medicare beneficiary with high drug costs (as defined in subsection (c)).

''(2) RESIDENCY RULES.—In applying paragraph (1), residency rules similar to the residency rules applicable to the State plan under title XIX shall apply.

''(b) LOW-INCOME MEDICARE BENEFICIARY DEFINED.—

''(1) IN GENERAL.—In this title, except as provided in section 2209(a)(2)(B), the term 'low-income medicare beneficiary' means an individual who—

''(A) is entitled to benefits under part A of title XVIII or enrolled under part B of such title, including an individual enrolled in a Medicare+Choice plan under part C of such title;

''(B) subject to subsection (d), is not entitled to medical assistance with respect to prescribed drugs under title XIX or under a waiver

under section 1115 of the requirements of such title;

"(C) is determined to have family income that does not exceed a percentage of the poverty line for a family of the size involved specified by the State that, subject to paragraph (2), may not exceed 175 percent; and

"(D) at the option of the State, is determined to have resources that do not exceed a level specified by the State.

"(2) STATE-ONLY DRUG ASSISTANCE PROGRAMS.—In the case of a State that has a State-based drug assistance program described in section 2203(e) that provides outpatient prescription drug coverage for individuals described in paragraph (1)(A) who have family income up to or exceeding 175 percent of the poverty line, the State may specify a percentage of the poverty line under paragraph (1)(C) that exceeds the income eligibility level specified by the State for such program but does not exceed 50 percentage points above such income eligibility level.

"(c) MEDICARE BENEFICIARY WITH HIGH DRUG COSTS DEFINED.—

''(1) IN GENERAL.—In this title, except as provided in section 2209(a)(2)(C), the term 'medicare beneficiary with high drug costs' means an individual—

''(A) who satisfies the requirements of subparagraphs (A) and (B) of subsection (b)(1);

''(B) whose family income exceeds the percentage of the poverty line specified by the State in accordance with subsection (b)(1)(C);

''(C) at the option of the State, whose resources exceed a level (if any) specified by the State in accordance with subsection (b)(1)(D); and

''(D) who has out-of-pocket expenses for outpatient prescription drugs and biologicals (including insulin and insulin supplies) for which outpatient prescription drug assistance is available under this title that exceed such amount as the State specifies in accordance with paragraph (2).

''(2) DETERMINATION OF OUT-OF-POCKET EXPENSES.—A State that elects to provide outpatient prescription drug assistance to an individual described in paragraph (1) shall provide the Secretary with the methodology and standards used to deter-

mine the individual's eligibility under subparagraph (D) of such paragraph.

''(d) ACCESS FOR MEDICAID EXPANSION STATES.—

''(1) IN GENERAL.—Notwithstanding any other provision of this title, with respect to any State that, as of the date of enactment of this title, has made outpatient prescription drug coverage for individuals described in paragraph (2) available through the State medicaid program under title XIX under a section 1115 waiver, the Secretary, in consultation with such State, shall establish procedures under which the State shall be able to receive payments from the allotment made available under section 2204 for such State for a fiscal year for purposes of offsetting the costs of making such coverage available to such individuals.

''(2) INDIVIDUALS DESCRIBED.—Individuals described in this paragraph are individuals who are—

''(A) entitled to benefits under part A of title XVIII or enrolled under part B of such title, including an individual enrolled in a Medicare+Choice plan under part C of such title; and

''(B) eligible for outpatient prescription drug coverage only, under a State medicaid pro-

gram under title XIX as a result of a section 1115 waiver.

''(e) INDIVIDUAL NONENTITLEMENT.—Nothing in this title shall be construed as providing an individual with an entitlement to outpatient prescription drug assistance provided under this title.

''SEC. 2203. COVERAGE REQUIREMENTS.

''(a) REQUIRED SCOPE OF COVERAGE.—

''(1) IN GENERAL.—The outpatient prescription drug assistance provided under the plan may consist of any of the following:

''(A) BENCHMARK COVERAGE.—Outpatient prescription drug coverage that is equivalent to the outpatient prescription drug coverage in a benchmark benefit package described in subsection (b).

''(B) AGGREGATE ACTUARIAL VALUE EQUIVALENT TO BENCHMARK PACKAGE.—Outpatient prescription drug coverage that has an aggregate actuarial value that is at least equivalent to one of the benchmark benefit packages.

''(C) EXISTING COMPREHENSIVE STATE-BASED COVERAGE.—Outpatient prescription drug coverage under an existing State-based program, described in subsection (e).

''(D) SECRETARY-APPROVED COVERAGE.—Any other outpatient prescription drug coverage that the Secretary determines, upon application by a State or group of States, provides appropriate outpatient prescription drug coverage for the population of medicare beneficiaries proposed to be provided such coverage.

''(2) CONSISTENT DESIGN.—A State or group of States may only select one of the options described in paragraph (1) (and, if the State or group chooses to provide outpatient prescription drug coverage that is equivalent to the outpatient prescription drug coverage in a benchmark benefit package, only one of the benchmark benefit package options described in subsection (b)) in order to provide outpatient prescription drug assistance in a uniform manner for the population of medicare beneficiaries provided such coverage.

''(b) BENCHMARK BENEFIT PACKAGES.—The benchmark benefit packages are as follows:

''(1) MEDICAID OUTPATIENT PRESCRIPTION DRUG COVERAGE.—In the case of—

''(A) a State, the outpatient prescription drug coverage provided under the State medicaid plan under title XIX; or

"(B) a group of States, the outpatient prescription drug coverage provided under the State medicaid plan under such title of one of the States in the group, as identified in the outpatient prescription drug assistance plan.

"(2) FEHBP-EQUIVALENT OUTPATIENT PRESCRIPTION DRUG COVERAGE.—The outpatient prescription drug coverage provided under the Standard Option Blue Cross and Blue Shield Service Benefit Plan described in and offered under section 8903(1) of title 5, United States Code.

"(3) STATE EMPLOYEE OUTPATIENT PRESCRIPTION DRUG COVERAGE.—In the case of—

"(A) a State, the outpatient prescription drug coverage provided under a health benefits coverage plan that is offered and generally available to State employees in the State involved; or

"(B) a group of States, the outpatient prescription drug coverage provided under a health benefits coverage plan that is offered and generally available to State employees in one of the States in the group, as identified in the outpatient prescription drug assistance plan.

''(4) OUTPATIENT PRESCRIPTION DRUG COVERAGE OFFERED THROUGH LARGEST HMO.—In the case of—

''(A) a State, the outpatient prescription drug coverage provided under a health insurance coverage plan that is offered by a health maintenance organization (as defined in section 2791(b)(3) of the Public Health Service Act) and has the largest insured commercial, nonmedicaid enrollment of covered lives of such coverage plans offered by such a health maintenance organization in the State involved; or

''(B) a group of States, the outpatient prescription drug coverage provided under a health insurance coverage plan that is offered by a health maintenance organization (as defined in section 2791(b)(3) of the Public Health Service Act) and has the largest insured commercial, nonmedicaid enrollment of covered lives of such coverage plans offered by such a health maintenance organization in one of the States involved.

''(c) DETERMINATION OF ACTUARIAL VALUE OF COVERAGE.—

''(1) IN GENERAL.—The actuarial value of outpatient prescription drug coverage offered under benchmark benefit packages and the outpatient prescription drug assistance plan shall be set forth in an opinion in a report that has been prepared—

''(A) by an individual who is a member of the American Academy of Actuaries;

''(B) using generally accepted actuarial principles and methodologies;

''(C) using a standardized set of utilization and price factors;

''(D) using a standardized population that is representative of the population to be covered under the outpatient prescription drug assistance plan;

''(E) applying the same principles and factors in comparing the value of different coverage;

''(F) without taking into account any differences in coverage based on the method of delivery or means of cost control or utilization used; and

''(G) taking into account the ability of a State or group of States to reduce benefits by taking into account the increase in actuarial

value of benefits coverage offered under the outpatient prescription drug assistance plan that results from the limitations on cost-sharing under such coverage.

''(2) REQUIREMENT.—The actuary preparing the opinion shall select and specify in the report the standardized set and population to be used under subparagraphs (C) and (D) of paragraph (1).

''(d) PROHIBITED COVERAGE.—Nothing in this section shall be construed as requiring any outpatient prescription drug coverage offered under the plan to provide coverage for an outpatient prescription drug for which payment is prohibited under this title, notwithstanding that any benchmark benefit package includes coverage for such an outpatient prescription drug.

''(e) DESCRIPTION OF EXISTING COMPREHENSIVE STATE-BASED COVERAGE.—

''(1) IN GENERAL.—A program described in this paragraph is an outpatient prescription drug coverage program for individuals who are entitled to benefits under part A of title XVIII or enrolled under part B of such title, including an individual enrolled in a Medicare+Choice plan under part C of such title, that—

''(A) is administered or overseen by the State and receives funds from the State;

''(B) was offered as of the date of the enactment of this title;

''(C) does not receive or use any Federal funds; and

''(D) is certified by the Secretary as providing outpatient prescription drug coverage that satisfies the scope of coverage required under subparagraph (A), (B), or (D) of subsection (a)(1).

''(2) MODIFICATIONS.—A State may modify a program described in paragraph (1) from time to time so long as it does not reduce the actuarial value (evaluated as of the time of the modification) of the outpatient prescription drug coverage under the program below the lower of—

''(A) the actuarial value of the coverage under the program as of the date of enactment of this title; or

''(B) the actuarial value described in subsection (a)(1)(B).

''(f) BENEFICIARY PREMIUMS AND COST-SHARING.—

''(1) DESCRIPTION; GENERAL CONDITIONS.—

''(A) DESCRIPTION.—

''(i) IN GENERAL.—An outpatient prescription drug assistance plan shall include a description, consistent with this subsection, of the amount of any premiums or cost-sharing imposed under the plan.

''(ii) PUBLIC SCHEDULE OF CHARGES.—Any premium or cost-sharing described under clause (i) shall be imposed under the plan pursuant to a public schedule.

''(B) PROTECTION FOR BENEFICIARIES.—The outpatient prescription drug assistance plan may only vary premiums and cost-sharing based on the family income of low-income medicare beneficiaries and, if applicable, medicare beneficiaries with high drug costs, in a manner that does not favor such beneficiaries with higher income over beneficiaries with low-income.

''(2) LIMITATIONS ON PREMIUMS AND COST-SHARING.—

''(A) NO PREMIUMS OR COST-SHARING FOR BENEFICIARIES WITH INCOME BELOW 100 PERCENT OF POVERTY LINE.—In the case of a low-income medicare beneficiary whose family in-

come does not exceed 100 percent of the poverty line, the outpatient prescription drug assistance plan may not impose any premium or cost-sharing.

"(B) OTHER BENEFICIARIES.—For low-income medicare beneficiaries not described in subparagraph (A) and, if applicable, medicare beneficiaries with high drug costs, any premiums or cost-sharing imposed under the outpatient prescription drug assistance plan may be imposed, subject to paragraph (1)(B), on a sliding scale related to income, except that the total annual aggregate of such premiums and cost-sharing with respect to all such beneficiaries in a family under this title may not exceed 5 percent of such family's income for the year involved.

"(g) RESTRICTION ON APPLICATION OF PREEXISTING CONDITION EXCLUSIONS.—The outpatient prescription drug assistance plan shall not permit the imposition of any preexisting condition exclusion for covered benefits under the plan and may not discriminate in the pricing of premiums under such plan because of health status, claims experience, receipt of health care, or medical condition.

"SEC. 2204. ALLOTMENTS.

"(a) APPROPRIATION.—

"(1) IN GENERAL.—For the purpose of providing allotments under this section to States, there is appropriated, out of any money in the Treasury not otherwise appropriated—

"(A) for fiscal year 2001, $1,300,000,000;

"(B) for fiscal year 2002, $4,600,000,000;

"(C) for fiscal year 2003, $9,700,000,000; and

"(D) for fiscal year 2004, $13,000,000,000.

"(2) AVAILABILITY.—Amounts appropriated under paragraph (1) shall only be available for providing the allotments described in such paragraph during the fiscal year for which such amounts are appropriated. Any amounts that have not been obligated by the Secretary for the purposes of making payments from such allotments under section 2205, or under contracts entered into under section 2209(b)(2)(B), on or before September 30 of fiscal year 2001, 2002, 2003, or 2004 (as applicable), shall be returned to the Treasury.

"(b) ALLOTMENTS TO 50 STATES AND DISTRICT OF COLUMBIA.—

''(1) IN GENERAL.—Subject to paragraph (3), of the amount available for allotment under subsection (a) for a fiscal year, reduced by the amount of allotments made under subsection (c) for the fiscal year, the Secretary shall allot to each State (other than a State described in such subsection) with an outpatient prescription drug assistance plan approved under this title the same proportion as the ratio of—

''(A) the number of medicare beneficiaries with family income that does not exceed 175 percent of the poverty line residing in the State for the fiscal year; to

''(B) the total number of such beneficiaries residing in all such States.

''(2) DETERMINATION OF NUMBER OF MEDICARE BENEFICIARIES WITH INCOME THAT DOES NOT EXCEED 175 PERCENT OF POVERTY.—For purposes of paragraph (1), a determination of the number of medicare beneficiaries with family income that does not exceed 175 percent of the poverty line residing in a State for the calendar year in which such fiscal year begins shall be made on the basis of the arithmetic average of the number of such medicare beneficiaries, as reported and defined in the 5 most re-

cent March supplements to the Current Population Survey of the Bureau of the Census before the beginning of the fiscal year.

''(3) MINIMUM ALLOTMENT.—In no case shall the amount of the allotment under this subsection for one of the 50 States or the District of Columbia for a fiscal year be less than an amount equal to 0.5 percent of the amount provided for allotments under subsection (a) for that fiscal year (reduced by the amount of allotments made under subsection (c) for the fiscal year). To the extent that the application of the previous sentence results in an increase in the allotment to a State or the District of Columbia above the amount otherwise provided, the allotments for the other States and the District of Columbia under this subsection shall be reduced in a pro rata manner (but not below the minimum allotment described in such preceding sentence) so that the total of such allotments in a fiscal year does not exceed the amount otherwise provided for allotment under subsection (a) for that fiscal year (as so reduced).

''(c) ALLOTMENTS TO TERRITORIES.—

''(1) IN GENERAL.—Of the amount available for allotment under subsection (a) for a fiscal year, the Secretary shall allot 0.25 percent among each of the

commonwealths and territories described in paragraph (3) in the same proportion as the percentage specified in paragraph (2) for such commonwealth or territory bears to the sum of such percentages for all such commonwealths or territories so described.

''(2) PERCENTAGE.—The percentage specified in this paragraph for—

''(A) Puerto Rico is 91.6 percent;

''(B) Guam is 3.5 percent;

''(C) the United States Virgin Islands is 2.6 percent;

''(D) American Samoa is 1.2 percent; and

''(E) the Northern Mariana Islands is 1.1 percent.

''(3) COMMONWEALTHS AND TERRITORIES.—A commonwealth or territory described in this paragraph is any of the following if it has an outpatient prescription drug assistance plan approved under this title:

''(A) Puerto Rico.

''(B) Guam.

''(C) The United States Virgin Islands.

''(D) American Samoa.

''(E) The Northern Mariana Islands.

''(d) TRANSFER OF CERTAIN ALLOTMENTS AND PORTIONS OF ALLOTMENTS.—

''(1) TRANSFER AND REDISTRIBUTION.—

''(A) IN GENERAL.—Subject to subparagraph (B), not later than 30 days after the date described in paragraph (2)—

''(i) 90 percent of the allotment determined for a fiscal year under subsection (b) or (c) for a State shall be transferred and made available in such fiscal year to the Secretary, acting through the Administrator of the Health Care Financing Administration, for purposes of carrying out the default program established under section 2209; and

''(ii) 10 percent of such allotment shall be redistributed in accordance with subsection (e).

''(B) APPLICABILITY.—Subparagraph (A) shall not apply if, not later than the date described in paragraph (2) for such fiscal year, a State submits a plan or is part of a group of States that submits a plan to the Secretary that the Secretary finds meets the requirements of section 2201(b).

''(2) DATE DESCRIBED.—The date described in this paragraph is—

''(A) in the case of fiscal year 2001, December 31, 2000; and

''(B) in the case of fiscal year 2002, 2003, or 2004, September 1 of the fiscal year preceding such fiscal year.

''(e) REDISTRIBUTION OF PORTION OF ALLOTMENTS.—With respect to a fiscal year, not later than 30 days after the date described in subsection (d)(2) for such fiscal year, the Secretary shall redistribute the total amount made available for redistribution for such fiscal year under subsection (d)(1)(A)(ii) to each State that submits a plan or is part of a group of States that submits a plan to the Secretary that the Secretary finds meets the requirements of this title. Such amount shall be redistributed in the same manner as allotments are determined under subsections (b) and (c) and shall be available only to the extent consistent with subsection (a)(2).

''SEC. 2205. PAYMENTS TO STATES.

''(a) IN GENERAL.—Subject to the succeeding provisions of this section, the Secretary shall pay to each State with a plan approved under section 2206(a)(2) (individually or as part of a group of States) from the State's allotment under section 2204, an amount for each quarter

equal to the applicable percentage of expenditures in the quarter—

''(1) for outpatient prescription drug assistance under the plan for low-income medicare beneficiaries and, if applicable, medicare beneficiaries with high drug costs in the form of providing coverage for outpatient prescription drugs that meets the requirements of section 2203; and

''(2) only to the extent permitted consistent with subsection (c), for reasonable costs incurred to administer the plan.

''(b) APPLICABLE PERCENTAGE.—For purposes of subsection (a), the applicable percentage is—

''(1) for low-income medicare beneficiaries with family incomes that do not exceed 135 percent of the poverty line, 100 percent; and

''(2) for all other low-income medicare beneficiaries and for medicare beneficiaries with high drug costs, the enhanced FMAP (as defined in section 2105(b)).

''(c) LIMITATION ON PAYMENTS FOR CERTAIN EXPENDITURES.—

''(1) GENERAL LIMITATIONS.—Funds provided to a State or group of States under this title shall only be used to carry out the purposes of this title.

''(2) ADMINISTRATIVE EXPENDITURES.—

''(A) IN GENERAL.—Subject to subparagraph (B), payment shall not be made under subsection (a) for expenditures described in subsection (a)(2) for a fiscal year to the extent the total of such expenditures (for which payment is made under such subsection) exceeds 10 percent of the total expenditures described in subsection (a)(1) made by—

''(i) in the case of a State that is not part of a group of States, the State for such fiscal year; and

''(ii) in the case of a group of States, the group for such fiscal year.

''(B) SPECIAL RULE.—With respect to the first fiscal year that a State or group of States provides outpatient prescription drug assistance under a plan approved under this title, the 10 percent limitation described in subparagraph (A) shall be applied—

''(i) in the case of a State that is not part of a group of States, to the allotment available for such State for such fiscal year; and

"(ii) in the case of a group of States, to the aggregate of the State allotments available for all the States in such group for such fiscal year.

"(3) USE OF NON-FEDERAL FUNDS FOR STATE MATCHING REQUIREMENT.—Amounts provided by the Federal Government, or services assisted or subsidized to any significant extent by the Federal Government, may not be included in determining the amount of the non-Federal share of plan expenditures required under the plan.

"(4) OFFSET OF RECEIPTS ATTRIBUTABLE TO PREMIUMS OR COST-SHARING.—For purposes of subsection (a), the amount of the expenditures under the plan shall be reduced by the amount of any premiums or cost-sharing received by a State.

"(5) PREVENTION OF DUPLICATIVE PAYMENTS.—

"(A) OTHER HEALTH PLANS.—No payment shall be made under this section for expenditures for outpatient prescription drug assistance provided under an outpatient prescription drug assistance plan to the extent that a private insurer (as defined by the Secretary by regulation and including a group health plan, a

service benefit plan, and a health maintenance organization) would have been obligated to provide such assistance but for a provision of its insurance contract which has the effect of limiting or excluding such obligation because the beneficiary is eligible for or is provided outpatient prescription drug assistance under the plan.

''(B) OTHER FEDERAL GOVERNMENTAL PROGRAMS.—Except as otherwise provided by law, no payment shall be made under this section for expenditures for outpatient prescription drug assistance provided under an outpatient prescription drug assistance plan to the extent that payment has been made or can reasonably be expected to be made promptly (as determined in accordance with regulations) under any other federally operated or financed health care insurance program identified by the Secretary. For purposes of this paragraph, rules similar to the rules for overpayments under section 1903(d)(2) shall apply.

''(d) ADVANCE PAYMENT; RETROSPECTIVE ADJUSTMENT.—The Secretary may make payments under this section for each quarter on the basis of advance estimates

of expenditures submitted by a State or group of States and such other investigation as the Secretary may find necessary, and may reduce or increase the payments as necessary to adjust for any overpayment or underpayment for prior quarters.

''(e) FLEXIBILITY IN SUBMITTAL OF CLAIMS.—Nothing in this section shall be construed as preventing a State or group of States from claiming as expenditures in any quarter of a fiscal year expenditures that were incurred in a previous quarter of such fiscal year.

''SEC. 2206. PROCESS FOR SUBMISSION, APPROVAL, AND AMENDMENT OF OUTPATIENT PRESCRIPTION DRUG ASSISTANCE PLANS.

''(a) INITIAL PLAN.—

''(1) SUBMISSION.—A State may receive payments under section 2205 with respect to a fiscal year if the State, individually or as part of a group of States, has submitted to the Secretary, not later than the date described in section 2204(d)(2), an outpatient prescription drug assistance plan that the Secretary has found meets the applicable requirements of this title.

''(2) APPROVAL.—Except as the Secretary may provide under subsection (e), a plan submitted under paragraph (1)—

''(A) shall be approved for purposes of this title; and

''(B) shall be effective beginning with a calendar quarter that is specified in the plan, but in no case earlier than October 1, 2000.

''(b) PLAN AMENDMENTS.—Within 30 days after a State or group of States amends an outpatient prescription drug assistance plan submitted pursuant to subsection (a), the State or group shall notify the Secretary of the amendment.

''(c) DISAPPROVAL OF PLANS AND PLAN AMENDMENTS.—

''(1) PROMPT REVIEW OF PLAN SUBMITTALS.—The Secretary shall promptly review plans and plan amendments submitted under this section to determine if they substantially comply with the requirements of this title.

''(2) 45-DAY APPROVAL DEADLINES.—A plan or plan amendment is considered approved unless the Secretary notifies the State or group of States in writing, within 45 days after receipt of the plan or amendment, that the plan or amendment is disapproved (and the reasons for the disapproval) or that specified additional information is needed.

''(3) CORRECTION.—In the case of a disapproval of a plan or plan amendment, the Secretary shall provide a State or group of States with a reasonable opportunity for correction before taking financial sanctions against the State or group on the basis of such disapproval.

''(d) PROGRAM OPERATION.—

''(1) IN GENERAL.—A State or group of States shall conduct the program in accordance with the plan (and any amendments) approved under this section and with the requirements of this title.

''(2) VIOLATIONS.—The Secretary shall establish a process for enforcing requirements under this title. Such process shall provide for the withholding of funds in the case of substantial noncompliance with such requirements. In the case of an enforcement action against a State or group of States under this paragraph, the Secretary shall provide a State or group of States with a reasonable opportunity for correction and for administrative and judicial appeal of the Secretary's action before taking financial sanctions against the State or group of States on the basis of such an action.

''(e) CONTINUED APPROVAL.—Subject to section 2201(d), an approved outpatient prescription drug assist-

ance plan shall continue in effect unless and until the State or group of States amends the plan under subsection (b) or the Secretary finds, under subsection (d), substantial noncompliance of the plan with the requirements of this title.

"SEC. 2207. PLAN ADMINISTRATION; APPLICATION OF CERTAIN GENERAL PROVISIONS.

''(a) PLAN ADMINISTRATION.—An outpatient prescription drug assistance plan shall include an assurance that the State or group of States administering the plan will collect the data, maintain the records, afford the Secretary access to any records or information relating to the plan for the purposes of review or audit, and furnish reports to the Secretary, at the times and in the standardized format the Secretary may require in order to enable the Secretary to monitor program administration and compliance and to evaluate and compare the effectiveness of plans under this title.

''(b) APPLICATION OF CERTAIN GENERAL PROVISIONS.—The following sections of this Act shall apply to the program established under this title in the same manner as they apply to a State under title XIX:

''(1) TITLE XIX PROVISIONS.—

''(A) Section 1902(a)(4)(C) (relating to conflict of interest standards).

''(B) Paragraphs (2), (16), and (17) of section 1903(i) (relating to limitations on payment).

''(C) Section 1903(w) (relating to limitations on provider taxes and donations).

''(2) TITLE XI PROVISIONS.—

''(A) Section 1115 (relating to waiver authority).

''(B) Section 1116 (relating to administrative and judicial review), but only insofar as consistent with this title.

''(C) Section 1124 (relating to disclosure of ownership and related information).

''(D) Section 1126 (relating to disclosure of information about certain convicted individuals).

''(E) Section 1128A (relating to civil monetary penalties).

''(F) Section 1128B(d) (relating to criminal penalties for certain additional charges).

''SEC. 2208. REPORTS.

''(a) IN GENERAL.—Each State or group of States administering a plan under this title shall annually—

''(1) assess the operation of the outpatient prescription drug assistance plan under this title in each fiscal year; and

''(2) report to the Secretary on the result of the assessment.

''(b) REQUIRED INFORMATION.—The annual report required under subsection (a) shall include the following:

''(1) An assessment of the effectiveness of the plan in providing outpatient prescription drug assistance to low-income medicare beneficiaries and, if applicable, medicare beneficiaries with high drug costs.

''(2) A description and analysis of the effectiveness of elements of the plan, including—

''(A) the characteristics of the low-income medicare beneficiaries and, if applicable, medicare beneficiaries with high drug costs assisted under the plan, including family income and access to, or coverage by, other health insurance prior to the plan and after eligibility for the plan ends;

''(B) the amount and level of assistance provided under the plan; and

''(C) the sources of the non-Federal share of plan expenditures.

''(c) ANNUAL REPORT OF THE SECRETARY.—The Secretary shall submit to Congress and make available to the public an annual report based on the reports required under subsection (a) and section 2209(b)(5), containing any conclusions and recommendations the Secretary considers appropriate.

"SEC. 2209. ESTABLISHMENT OF DEFAULT PROGRAM.

''(a) PROGRAM AUTHORITY.—

''(1) IN GENERAL.—With respect to a fiscal year, in the case of a State that fails to submit (individually or as part of a group of States) an approved outpatient prescription drug assistance plan to the Secretary by the date described in section 2204(d)(2) for such fiscal year, outpatient prescription drug assistance to low-income medicare beneficiaries and, subject to the availability of funds, medicare beneficiaries with high drug costs, who reside in such State shall be provided during such fiscal year by the Secretary, through the Administrator of the Health Care Financing Administration, in accordance with this section.

''(2) DEFINITIONS.—In this section:

''(A) CONTRACTOR.—The term 'contractor' means a pharmaceutical benefit manager or other entity that meets standards established by

the Administrator of the Health Care Financing Administration for the provision of outpatient prescription drug assistance under a contract entered into under this section.

''(B) LOW-INCOME MEDICARE BENEFICIARY.—The term 'low-income medicare beneficiary' means an individual who—

''(i) satisfies the requirements of subparagraphs (A) and (B) of section 2202(b)(1);

''(ii) is determined to have family income that does not exceed a percentage of the poverty line for a family of the size involved specified by the Administrator of the Health Care Financing Administration that may not exceed 135 percent; and

''(iii) at the option of the Administrator of the Health Care Financing Administration, is determined to have resources that do not exceed a level specified by such Administrator.

''(C) MEDICARE BENEFICIARY WITH HIGH DRUG COSTS.—The term 'medicare beneficiary with high drug costs' means an individual—

''(i) who satisfies the requirements of subparagraphs (A) and (B) of section 2202(b)(1);

''(ii) whose family income exceeds the percentage of the poverty line specified by the Administrator of the Health Care Financing Administration under subparagraph (B)(ii) for a low-income medicare beneficiary residing in the same State;

''(iii) whose resources exceed a level (if any) specified by the Administrator of the Health Care Financing Administration under subparagraph (B)(iii) for a low-income medicare beneficiary residing in the same State; and

''(iv) with respect to any 3-month period, who has out-of-pocket expenses for outpatient prescription drugs and biologicals (including insulin and insulin supplies) for which outpatient prescription drug assistance is available under this title that exceed a level specified by such Administrator (consistent with the availability of funds for the operation of the program

established under this section in the State where the beneficiary resides).

''(b) ADMINISTRATION.—In administering the default program established under this section, the Administrator of the Health Care Financing Administration shall—

''(1) establish procedures to determine the eligibility of the low-income medicare beneficiaries and medicare beneficiaries with high drug costs described in subsection (a) for outpatient prescription drug assistance;

''(2) establish a process for accepting bids to provide outpatient prescription drug assistance to such beneficiaries, awarding contracts under such bids, and making payments under such contracts;

''(3) establish policies and procedures for overseeing the provision of outpatient prescription drug assistance under such contracts;

''(4) develop and implement quality and service assessment measures that include beneficiary quality surveys and annual quality and service rankings for contractors awarded a contract under this section;

''(5) annually assess the program established under this section and submit a report to the Secretary containing the information required under section 2208(b); and

''(6) carry out such other responsibilities as are necessary for the administration of the provision of outpatient prescription drug assistance under this section.

''(c) CONTRACT REQUIREMENTS.—

''(1) AUTHORITY; TERM.—

''(A) USE OF COMPETITIVE PROCEDURES.—

''(i) FISCAL YEAR 2001.—With respect to fiscal year 2001, the Administrator of the Health Care Financing Administration may enter into contracts under this section without using competitive procedures, as defined in section 4(5) of the Office of Federal Procurement Policy Act (41 U.S.C. 403(5)), or any other provision of law requiring competitive bidding.

''(ii) FISCAL YEARS 2002, 2003, AND 2004.—With respect to fiscal years 2002, 2003, and 2004, the Administrator of the Health Care Financing Administration shall award contracts under this section using competitive procedures (as so defined).

''(B) TERM.—Each contract shall be for a uniform term of at least 1 year, but may be made automatically renewable from term to term in the absence of notice of termination by either party.

''(2) BENEFIT.—The contract shall require the contractor to provide a low-income medicare beneficiary and, if applicable, a medicare beneficiary with high drug costs, outpatient prescription drug assistance that is equivalent to the FEHBP-equivalent benchmark benefit package described in section 2203(b)(2) in a manner that is consistent with the provisions of this title as such provisions apply to a State that provides such assistance.

''(3) QUALITY AND SERVICE ASSESSMENT.—The contract shall require the contractor to cooperate with the quality and service assessment measures implemented in accordance with subsection (b)(4).

''(4) PAYMENTS.—The contract shall specify the amount and manner by which payments (including any administrative fees) shall be made to the contractor for the provision of outpatient prescription drug assistance to low-income medicare bene-

ficiaries and, if applicable, medicare beneficiaries with high drug costs.

''(d) FUNDING.—

''(1) AGGREGATE OF TRANSFERRED AMOUNTS.—The Secretary, through the Administrator of the Health Care Financing Administration, shall use the aggregate of the amounts transferred and made available under section 2204(d)(1)(A)(i) for purposes of carrying out the default program established under this section. Such aggregate may be used to provide outpatient prescription drug assistance to any low-income medicare beneficiary, and, subject to the availability of funds, medicare beneficiary with high drug costs, who resides in a State described in subsection (a)(1).

''(2) LIMITATION ON ADMINISTRATIVE COSTS.—Administrative expenditures incurred by the Secretary or the Administrator of the Health Care Financing Administration for a fiscal year to carry out this section (other than administrative fees paid to a contractor under a contract meeting the requirements of subsection (c))—

''(A) shall be paid out of the aggregate amounts described in paragraph (1); and

''(B) may not exceed an amount equal to 1 percent of all premiums imposed for such fiscal year to provide outpatient prescription drug assistance to low-income medicare beneficiaries and medicare beneficiaries with high drug costs under this section.

''(e) TERMINATION.—Except as provided in section 2201(d)(2), the program established under this section shall terminate on September 30, 2004.

''SEC. 2210. DEFINITIONS.

''In this title:

''(1) COST-SHARING.—The term 'cost-sharing' means a deductible, coinsurance, copayment, or similar charge, and includes an enrollment fee.

''(2) OUTPATIENT PRESCRIPTION DRUG ASSISTANCE.—

''(A) IN GENERAL.—The term 'outpatient prescription drug assistance' means, subject to subparagraph (B), payment for part or all of the cost of coverage of self-administered outpatient prescription drugs and biologicals (including insulin and insulin supplies) for low-income medicare beneficiaries and, if applicable, medicare beneficiaries with high drug costs.

''(B) EXCLUSIONS.—Such term does not include payment or coverage with respect to—

''(i) items covered under title XVIII; or

''(ii) items for which coverage is not available under a State plan under title XIX.

''(3) OUTPATIENT PRESCRIPTION DRUG ASSISTANCE PLAN; PLAN.—Unless the context otherwise requires, the terms 'outpatient prescription drug assistance plan' and 'plan' mean an outpatient prescription drug assistance plan approved under section 2206.

''(4) GROUP HEALTH PLAN; GROUP HEALTH INSURANCE COVERAGE; ETC.—The terms 'group health plan', 'group health insurance coverage', and 'health insurance coverage' have the meanings given such terms in section 2791 of the Public Health Service Act (42 U.S.C. 300gg–91).

''(5) POVERTY LINE.—The term 'poverty line' has the meaning given such term in section 673(2) of the Community Services Block Grant Act (42 U.S.C. 9902(2)), including any revision required by such section.

''(6) PREEXISTING CONDITION EXCLUSION.—The term 'preexisting condition exclusion' has the meaning given such term in section 2701(b)(1)(A) of the Public Health Service Act (42 U.S.C. 300gg(b)(1)(A)).

''(7) STATE.—The term 'State' has the meaning given such term for purposes of title XIX.''.

(b) CONFORMING AMENDMENTS.—

(1) DEFINITION OF STATE.—Section 1101(a)(1) of the Social Security Act (42 U.S.C. 1301(a)(1)) is amended in the first and fourth sentences, by striking ''and XXI'' each place it appears and inserting ''XXI, and XXII''.

(2) TREATMENT AS STATE HEALTH CARE PROGRAM.—Section 1128(h) of such Act (42 U.S.C. 1320a–7(h)) is amended—

(A) in paragraph (3), by striking ''or'' at the end;

(B) in paragraph (4), by striking the period at the end and inserting '', or''; and

(C) by adding at the end the following new paragraph:

''(5) an outpatient prescription drug assistance plan approved under title XXII.''.

SEC. 3. ELECTION BY LOW-INCOME MEDICARE BENEFICIARIES AND MEDICARE BENEFICIARIES WITH HIGH DRUG COSTS TO SUSPEND MEDIGAP INSURANCE.

Section 1882(q) of the Social Security Act (42 U.S.C. 1395ss(q)) is amended—

(1) in paragraph (5)(C), by striking ''this paragraph or paragraph (6)'' and inserting ''this paragraph, or paragraph (6) or (7)''; and

(2) by adding at the end the following new paragraph:

''(7) Each medicare supplemental policy shall provide that benefits and premiums under the policy shall be suspended at the request of the policyholder if the policyholder is entitled to benefits under section 226 and is covered under an outpatient prescription drug assistance plan (as defined in section 2210(3)) or provided outpatient prescription drug assistance under the program established under section 2209. If such suspension occurs and if the policyholder or certificate holder loses coverage under such plan or program, such policy shall be automatically reinstituted (effective as of the date of such loss of coverage) under terms described in subsection (n)(6)(A)(ii) as of the loss of such coverage if the

policyholder provides notice of loss of such coverage within 90 days after the date of such loss.''.

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